AGENDA ITEM # 5
MEETING OF 5/4/95
EXEC. ____ PUBLIC ✓

DRAFT

Advertising of Specialty, Subspecialty or Certification

(a). As used in this section.

(1) "specialty board" means a board which certifies doctors of chiropractic in a specialty or subspecialty of chiropractic.

(2) "Specialty or subspecialty area of chiropractic" means a distinct and well-defined field of chiropractic practice. It includes special concern with diagnostic and therapeutic modalities of patients' health problems, or it may concern health problems according to age, sex, organ system, body region, or the interaction between patients and their environment. A chiropractic specialty promotes the standards of practice within its specialty.

(b) If a doctor of chiropractic advertises that they specializes or are certified by a specialty board in a specialty or subspecialty area of chiropractic the specialty board shall be approved by the Board of Chiropractic Examiners and shall comply with all of the following requirements.

(1) The primary purpose of the specialty board shall be certification of a specialty or subspecialty. The specialty board shall encompass the broad areas of the specialty or subspecialty-

(2) The specialty board shall not restrict itself to a single modality of treatment which may be part of a broader specialty or subspecialty.

(3) The specialty board shall be a nonprofit corporation which shall have at least 100 members located in at least fifteen states. Each member shall possess a clear and unrestricted license to practice chiropractic.

(4) The specialty board shall have articles of incorporation, a constitution, or a charter and bylaws which describe its operation. The bylaws shall:

(A) provide for an independent and stable governing body with staggered, limited terms of not more than six years that is internally-appointed or selected by the members.

(B) set forth the requirements and policies for certification by the specialty board.

(C) require that the specialty board establish requirements for the fair evaluation of all applicants.

(D) require that the specialty board determine whether applicants have adequate preparation in accordance with the standards established by the specialty board.

(E) require evidence that applicants have acquired capability in a specialty or subspecialty area of chiropractic and will demonstrate special knowledge in that field.

(F) require that the specialty board conduct comprehensive evaluations of the knowledge and experience of applicants.

(5) The specialty board shall have standards for determining that those who are certified possess the knowledge and skills essential to provide competent care in the designated specialty or subspecialty area.

(6) More than 80 percent of the specialty board's revenue for continuing operations shall be from certification and examination fees, membership fees and interest and investment income.

(7) The specialty board shall require all applicants who are seeking certification to have satisfactorily completed a postgraduate training program taught by a school or college recognized by the Council on Chiropractic Education or an accrediting agency recognized by the United States Department of Education. The postgraduate training program shall be a minimum of 300 hours and shall include identifiable training in the specialty or subspecialty area of chiropractic in which the doctor of chiropractic is seeking certification.

(8) The specialty board shall require all doctors of chiropractic who are seeking certification to successfully pass a written or an oral examination or both, which tests the applicants' knowledge and skills in the specialty or subspecialty area of chiropractic. All or part of the examination may be delegated to a testing organization. All examinations shall be subject to a current psychometric evaluation.

(9) The specialty board shall issue certificates to those doctors of chiropractic who are found qualified under the stated requirements of the specialty board.

(c)(1) Upon request, the Board of Chiropractic Examiners will approve a specialty board if it meets the criteria set forth in these regulations. The Board of Chiropractic Examiners may withdraw the approval of a specialty board if it finds that the specialty board fails to meet or maintain the criteria set forth in these regulations.

(2) Within 60 working days of receipt of an application for specialty board approval, the Board of Chiropractic Examiners shall inform the applicant in writing that it is either complete and accepted for filing or that it is deficient while specifying information or documentation that is required to complete the application.

(3) Within 120 calendar days from the date of filing of a completed application, the Board of Chiropractic Examiners shall inform the applicant in writing of its decision regarding the applicant's approval as a specialty board.

(d) Specialty boards approved by the Board of Chiropractic Examiners shall certify every three years from the date of approval that they continue to meet the requirements of these regulations.

(e) The Board of Chiropractic Examiners shall conduct such evaluations as it deems appropriate to ensure that applicant boards meet the criteria of these regulations.

(f) Doctors of chiropractic who are certified by specialty boards which are incorporated, or organized as an association on the effective date of these regulations, may advertise that they specialize or are certified by the specialty board for eighteen months from the effective date of these regulations. During that time, the specialty board shall demonstrate to the satisfaction of the Board of Chiropractic Examiners that it meets the requirements of this section. If a specialty board cannot demonstrate that it meets the requirements of this section eighteen months following the effective date of these regulations, its members may not thereafter advertise specialization or certification by

that board. This period may be extended for one year if the Board of Chiropractic determines that the specialty board is making a good faith effort towards meeting the requirements of this section.

Doctors of chiropractic who are certified by specialty boards which are incorporated, or organized as an association after the effective date of these regulations, may not advertise that they specialize or are certified by a specialty board until the specialty board demonstrates to the satisfaction of the Board of Chiropractic Examiners that it meets the requirements of this section

Note Authority cited: Section 651 and 2015, Business and Professions Code; and Section 15376, Government Code. Reference Section 651, Business and Professional Code; and Section 15376, Government Code.

???Option for BCE to not approve ,,,public safety etc...

American College of Chiropractic Specialists, Inc. is an active California Corporation as of October 2004, copy of record of corporation included.

American College of Chiropractic Specialties (or Specialists? - NOT incorporated) started at LACC in the late 1930s or early 1940s. Their archives may hold files that are pertinent. Had counsels: Orthopedics, neurology, psychiatry, proctology, ENT... Old editions of Chirogram has information.

Merrill Cook, D.C., 714-896-8786 (office) 714-894-4986 (home) was Assistant Dean of Post-Graduate Education at LACC; held records of certificates issued and to whom. May have turned files over to American College of Chiropractic Orthopedics.

William P Valusek, DC, director of membership for ACCO, 1030 Broadway # 10, El Centro, CA 92243 (619) 352-1452.

Other sources of info:

F Maynard Lipe, DC, 619-343-2193, founder of ACCO

Leonard Savage, DC, 818-763-7628; 213-877-0779; 3130559-7415; 12603 Moorpark, Studio City, CA orthopedic counsel involvement.

Leonard Tune, DC, 818-883-8666, 7023 Owensmouth Av, Canoga park, CA

Rume Hanning, DC, 310-439-0965, 5929 Naples Plaza, Long Beach, CA; may know of disposition of records of "former" ACCO.

STATE OF CALIFORNIA — PETE WILSON, *Governor*

BOARD OF CHIROPRACTIC EXAMINERS
3401 FOLSOM BOULEVARD, SUITE B
SACRAMENTO, CA 95816
TELEPHONE: (916) 227-2790

AGENDA——May 4, 1995

NOTICE OF PUBLIC HEARING--notice is hereby given that pursuant to the call of Chairperson, Lloyd E. Boland, D.C., a public meeting of the Board of Chiropractic Examiners will be held at:

State Capitol
Room 127
Sacramento, California

CONTACT PERSON: Vivian R. Davis
(916) 227-2790

9:00 am PETITION FOR REDUCTION OF PENALTY: Dr. Robin Burdt, DC
10:30 am PETITION FOR RESTORATION OF LICENSE: Dr. Marcus Pride, DC
noon LUNCH

Pursuant to the Bagley-Keene Open Meeting Act, Government Code Section 11126(c) and (d), the following closed session items will be heard prior to the public session of the meeting.

1:00 pm
1. Disciplinary Actions
2. Examinations:
   a. Discussion Re: exam development
   b. Commissioner Applications
3. Consult with Legal Counsel
4. Personnel Matters

2:00 pm *OPEN SESSION*
CONTINUING EDUCATION COMMITTEE MEETING (Discuss seminars presented for approval on or before April 5, 1995)

2:30 pm *OPEN SESSION* *regular business meetings*

1.	Approval of Action Taken in Closed Session	(action)
2.	Approval of Minutes: March 30, 1995	(action)
3.	Staff Report:	(information/action)
	a. Registration of Chiropractic Corporations	
	b. Requests for Duplicate Licenses	
	c. Consideration of Reciprocity Applications	
	d. Consideration of Continuing Education Seminars	
	e. Executive Director's Report	
4.	Josephine Cardone: Request to Waive Prerequisites based upon 11 years practice	(action)
5.	Regulatory Language: Specialty Certification (§ 311.5)	(information/action)
6.	Discussion re: Renewal Requirements for Forfeiture License	(information/action)
7.	Regulatory Language: Referral Services (§ 317.1)	(information/action)
8.	Amended Language re: responsibility for conduct (§ 316)	(information/action)
9.	Proposed Regulatory Language re: § 125.3, Business and Professions Code (cost recovery)	(information/action)
10.	Report on Meeting with Board of Veterinary Medicine	(information/action)
11.	Regulatory Language: Continuing Education Faculty Disclosures	(information/action)
12.	New Business	(information/action)

4:30 pm ADJOURNMENT

STATE OF CALIFORNIA PETE WILSON, Governor

BOARD OF CHIROPRACTIC EXAMINERS
FOLSOM BOULEVARD, SUITE B
SACRAMENTO, CA 95816
TELEPHONE: (916) 227-2790

MINUTES

OF THE
BOARD OF CHIROPRACTIC EXAMINERS
HELD AT

State Capitol
Room 127
Sacramento, California

May 4, 1995

The Public meeting of the Board of Chiropractic Examiners was called to order at 2:35 p.m. by Chairman Lloyd E. Boland, D.C.

Present were:

Lloyd E. Boland, D.C. – Chairman
Michael J. Martello, D.C. – Vice-Chairman
Louis E. Newman, D.C.
John D. Bovée, Public Member
Rosa-Mei Lee, Ph. D., Public Member

Also Present were:

Joel Primes, Deputy Attorney General
Vivian R. Davis, Executive Director
E. Carol Bernal, Management Services Technician

Continuing Education Committee Meeting

Two of the members of the Continuing Education Committee — Dr. Martello and Dr. Boland — were present.

They discussed the seminars submitted for approval on or before April 5, 1995 and prepared recommendations to be made before the full Board under Agenda Item 3(d).

Agenda Item 5 *Regulatory Language: Specialty Certification*

Dr. Martello submitted the following language on specialty certifications:

Advertising of Specialty, Subspecialty, or Certification

(a). As used in this section

(1) "specialty board" means a board which certifies doctors of chiropractic in a specialty or subspecialty of chiropractic.

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Specialty Certification (*continued*)

(4) The specialty board shall have articles of incorporation, a constitution, or a charter and bylaws which describe its operation. The bylaws shall:

(A.) provide for an independent and stable governing body with staggered, limited terms of not more than six years that is internally-appointed or selected by the members.

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(D.) require that the specialty board determine whether applicants have adequate preparation in accordance with the standards established by the specialty board.

(E.) require evidence that the applicants have acquired capability in a specialty or subspecialty area of chiropractic and will demonstrate special knowledge in that field.

(F.) require that the specialty board conduct comprehensive evaluations of the knowledge and experience of the applicants.

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Specialty Certification (*continued*)

(7) The specialty board shall require all applicants who are seeking certification to have satisfactorily completed a postgraduate training program taught by a school or college recognized by the Council on Chiropractic Education or an accrediting agency recognized by the United States Department of Education. The postgraduate training program shall be a minimum of 300 hours and shall include identifiable training in the specialty or subspecialty area of chiropractic in which the doctor of chiropractic is seeking certification.

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Specialty Certification (*continued*)

(2) Within 60 working days of receipt of an application for specialty board approval, the Board of Chiropractic Examiners shall inform the applicant in writing that it is either complete and accepted for filing or that it is deficient while specifying information or documentation that is required to complete the application.\

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Specialty Certification (*continued*)

> Doctors of chiropractic who are certified by specialty boards which are incorporated, or organized as an association after the effective date of these regulations, may not advertise that they specialize or are certified by a specialty board until the specialty board demonstrates to the satisfaction of the Board of Chiropractic Examiners that it meets the requirements of this section.

The language is not intended to keep doctors from taking extended training programs, but is meant to correct problems with the way graduates of these programs advertise their certification. Doctors have been using the word "certified" in advertising whether they have taken a short course or a full three-year program.

The Medical Board already has regulations addressing medical specialties. Part of this language is based on or inspired by the Medical Board's language.

In reply to a question from the audience, Dr. Boland stated that the Board is given authority to regulate advertising by its regulations. Mr. Primes commented that the language has taken into account the balance between freedom of speech issues and Section 650 of the Business and Professions Code. The language is not meant to prohibit doctors from advertising certification through legitimate specialty programs. Differences between duration of programs could possibly be handled through modifiers to the phrase "certified specialist".

Dr. Martello has sent letters requesting input from specialty boards and has received one reply, which was in favor of board recognition and regulation of specialty boards. The biggest problem will be in judging the use of the word "certified".

Some of the proposals were: to have three levels ("diplomate"or "board certified", "Certificate of program completion", and "Certificate of course completion"); to require including the number of hours in advertising language; and to use the phrases "Level One," "Level Two," and "Level Three," only allowing use of the term "certified" with "Level Three".

Mr. Primes cited a Supreme Court case relating to "certified financial planners". The Court ruled that the group had a legitimate method of determining course completion and should therefore be allowed use of the term "certified".

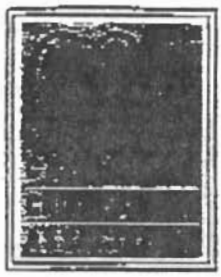
New Business (continued)

The meeting was adjourned.

Lloyd E. Boland, D.C., Chairman

Michael J. Martello, D.C., Vice-Chairman

Believe that AGO representative investigated and found the BCE does not have the authority to adopt a regulation such as this.



CALIFORNIA
CHIROPRACTIC
ASSOCIATION

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Folsom Boulevard
Suite 575
Sacramento
California
95826
(916) 387-6111
FAX
(916) 387-6222

"Your Health,
Our Concern."

June 22, 1995

Lloyd Boland, D.C., Chair
State Board of Chiropractic Examiners
3401 Folsom Blvd., Suite B
Sacramento, CA 95816

Dear Dr. Boland:

Per the request of Dr. Michael Martello, I have attached language which could be incorporated into your proposed regulation regarding specialty groups. Thank you for the opportunity to provide input.

We understand that the reason the State Board of Chiropractic Examiners (Board) is pursuing this regulatory change is the opinion that Section 651 of the Business and Professions Code requires the adoption of regulations regarding the advertising of specialty designations. Our legal counsel has reviewed the section and disagrees with this analysis, and we concur. Our reasoning is as follows:

1. Section 651 (h) (5)A and (5)(B) concern the advertising of certification programs and other specialty designations by health care providers who are licensed under Chapter 4 (commencing with Section 1600). Section 651 (5)(B) goes into substantial detail about the advertising of specialties by medical doctors. Neither Section 651 (h) (5)(A) nor (5)(B) concern doctors of chiropractic. The Chiropractic Act is covered under Section 1000.

2. Section 651 (i) makes an all encompassing statement requiring boards to adopt regulations implementing the provisions of this section. It states:

> "(i) Each of the healing arts boards and committees and examining committees within Division 2 shall adopt appropriate regulations to enforce this section...
>
> Each of the healing arts boards and committee and examining committees within Division 2 shall, by regulation, define those efficacious services to be advertised by business or professions under their jurisdiction for the purpose of determining whether advertisements are false or misleading." (Emphasis added)

The Board already has sections of the Chiropractic Act as well as Board regulations dealing with advertising. I point to Sections 10 and 15 of the Act as well as Rule 310.2, Rule 311, and Rule 317 (o), (t) and (u). Additionally, the Board has proposed regulations on information/referral bureaus.

The bigger question is whether "statutorily" the Board falls "within" the provisions of Division 2, for the purposes of Section 651 (i), as some on the Board conclude. We believe the Board does not fall "within" Division 2 for the purposes of this provision, and that Section 651 (i)'s mandatory requirement to promulgate specialty board regulations thus does not apply to the Board. As you know, the Chiropractic Act was created by an initiative measure. Accordingly, with the exception of Section 12.5 of the Chiropractic Act which specifically authorizes the legislature to establish license renewal and application fees, any other amendments to the Act (or requirements that the Board adopt regulation) require the approval of the voters. The location of the Chiropractic Act in the Business and Professions Code, or for that matter in the Division, is a decision by the publisher and not a statutory decision by the legislature. (Indeed, while West Publishers print the Act after Section 1000, Deerings prints the Act as an appendix at the end of the code.) To take any other position might jeopardize the Board's current independence as a regulatory agency. For example, Section 101 (q) specifically lists the State Board of Chiropractic Examiners under the Department of Consumer Affairs. It is there for convenience and not statutory requirements, since the voters have not required that the State Board of Chiropractic Examiners be part of the Department of Consumer Affairs.

The Board's ability to be an independent agency, outside the purview of the Department of Consumer Affairs, is a result of the initiative status. Quoting provisions of the Business and Professions Code and interpreting the Board of Chiropractic Examiners as being participants along with other healing arts boards "within" Division 2, without specific provisions in the Chiropractic Act, would weaken the Board's position. We do not believe that any need for this regulation has been demonstrated.

Thank you for the opportunity to comment. While we strongly disagree that the Board needs to take this action, we are providing the attached language should you decide to proceed with a regulation for specialty groups.

If you require further information, please contact me through the CCA office.

Sincerely,

Michael D Pedigo D.C.

Michael D. Pedigo, D.C.
CCA President

MDP:tlh/h:\b_crspnd\mdp06035.doc

Enclosure

cc: CCA Board of Directors
Members, State Board of Chiropractic Examiners

ATTACHMENT

Insert to proposed advertising regulation adding new subsection (g)

(g) Nothing in this section shall be construed to prevent a doctor of chiropractic from advertising that he or she is certified or credentialed in a specialty, subspecialty or area of practice of chiropractic (such as managed care or industrial injury evaluation) by a professional chiropractic association or its nonprofit educational affiliate if all of the following requirements are met:

(1) The association (or nonprofit educational affiliate) offers a substantive course of instruction in the specialty, subspecialty or area of practice requiring doctors of chiropractic who are seeking to be certified or credentialed to pass an oral or written examination or both which tests the applicant's knowledge and skills in the specialty, subspecialty or area of practice; and

(2) The association/nonprofit educational affiliate and its educational program are approved by the Board of Chiropractic Examiners.

Submitted by California Chiropractic Association
June 22, 1995

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GTE Yellow Pages - Los Angeles, 1995

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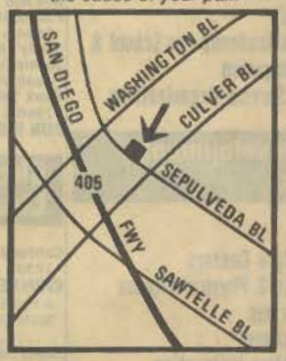

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James Ramaglino, D.C.
Certified Disability Evaluator; Member: American and California Chiropractic Associations

Deborah E. Medoff, D.C.
Diplomate: National Board of Chiropractic Examiners; Member: American & California Chiropractic Associations

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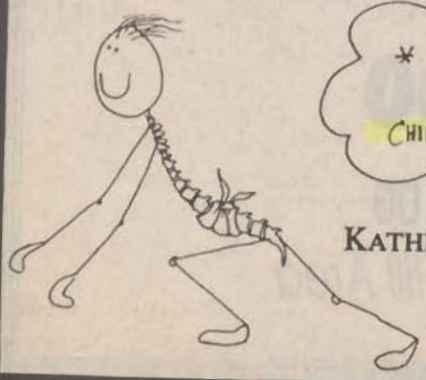
The Community Yellow Pages, 1995 (Los Angeles)



* FRAMEWORK *

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Doctor of Chiropractic

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The value of diplomate programs

by Bret MacDermott, D.C., DACS

Ten years ago, micro brews and bottled water were relatively new and unknown commodities. Now, restaurants offer more in options of water and micro brews than they do in standard drinks. And, they charge more for the uniqueness of the product.

Over the last two decades, chiropractic has been changing, just like consumers. Until recently, a Doctorate Degree in chiropractic used to be the norm. In their questioning today, however, attorneys don't ask "if" you have post-graduate degrees but rather "which ones." Diplomate programs are now offered in just about every imaginable field related to chiropractic, health and diagnostics.

Business promotion seminars and practice management companies used to predominate the ads in chiropractic periodicals. Now, there is a dominance of competing ads for different Diplomate programs. Envisioning this as a progressive and favorable change leading to building the profession and its practices through knowledge, rather than forms and scripts, one still needs to ask, "What is the Diplomate program for?"

Diplomate programs are offered in a wide array of subjects: nutrition, orthopedics, neurology, radiology, sports injuries, pediatrics, and applied chiropractic science, to name some. While all have valuable information, are philosophy, science, and art all interwoven in the program? It appears the specialties having approached existing boundaries are now entering into other camps.

What would the response be of the chiropractic profession if *Medical Economics* or other medical journals were advertising Diplomate programs in spinal adjustments and chiropractic? Chiropractic was up in arms with full-assault legal agendas when physical therapists wanted to offer their services without the need of a referral and when medical practitioners gave opinions on chiropractic care. So, if there are going to be Diplomate programs, shouldn't they focus on the philosophy, science and art of *chiropractic?*

New graduates coming out of school have all the text knowledge they need to be quality assets to the profession. What they need is the valuable time of hands-on experience. New doctors should not buy into the hierarchy model of more degrees means better. Instead, they should seek out experienced field doctors to act as mentors.

The decision to pursue a Diplomate degree must be well thought out. Having more letters after one's name does not give a person the right to raise the flag of "don't tread on me." In other words, the same nonsense with insurance and lawyers and IME's will still occur. The difference is knowledge and certainty. Knowing you know what you know is certainty. It's the same as when you give the right adjustment, at the right time, at the right place.

The students' goal in chiropractic college is, officially, to learn - - but really it's to get the grades, get through and graduate. Remembering facts and physiology to explain to a jury or arbitration committee is, no doubt, far from a student's mind. If your cranium is leak-proof and you "got it," more power to you. For most of the practitioners I speak with, it's a journey of constant learning, discovering and re-learning, somewhat like a mental Nintendo game.

As reflex-cycles begin to register, you're suddenly exposed to new levels of knowledge and perceptions. With every deposition or opportunity to testify, the mental learning game begins, starting with the basics, "this is a spine," followed by re- learning to levels of certainty.

Is this information only available in Diplomate programs? Absolutely not! The text books and journal reviews are out there for any practitioner to review. The advantage of orchestrated programs such as the DACS is that it delivers a disciplined schedule, you are accountable, and you are coached by the best in the field.

"If there are going to be Diplomate programs, shouldn't they focus on the philosophy, science and art of chiropractic?"

As mentioned earlier, attorneys ask for your credentials. But, remember, credentials alone do not qualify you as an expert. During questioning, attorneys are listening for confidence, clarity, and skill. This includes communicating the truth of knowledge, and avoiding undefensible opinions.

So, is a Diplomate program for everybody? No. Does it make you a better adjuster? No. It does give you knowledge, and with knowledge comes power and certainty. ❑

DCs with False Credentials Embarrass our Profession

FROM THE PUBLISHER

Donald D. Harrison, MS, DC, F.I.C.A.
Publisher
and Originator of the CBP Technique

Basic standards are important to insure quality in any profession, whether it be food service, engineering, health care, etc. Many might have complaints about CCE and its original methods and intentions, but few can argue that CCE has not been good for our profession, especially as Chiropractic has experienced improved relations with State and Federal Governments due to NIH recognition of CCE. With the accreditation of Sherman College of Chiropractic and the new Bridgeport Chiropractic College, we have all students coming from accredited colleges when they take their State Board Exams. Now we have a new direction to focus some academic standards: Credentials of Chiropractors. There are several DCs using a multitude of initials after their names. Sometimes these initials represent many hours of study in accredited programs, while others are fictitious and

see "ACCREDITATION" on page 4

To Impress Patients and Seminar Attendees

Some DCs Pad Their Credentials with a PhD from a Diploma Mill

In the past few months, while debating the errors in ASBE Technique's AP procedures with ASBE instructors and practitioners (see the April 95 issue, July 95 issue, and letters to the editor in this issue), I received a letter from Dr. Ronald Aragona (see his letter to the editor this issue) and a copy of his "PhD" diploma from Columbia Pacific "University." In his letter, Dr. Aragona claims that Dr. Lowell Ward, originator of Spinal Stressology technique, got his "PhD" from the same "university." A call to Dr. Ward confirmed that he had a PhD from CP"U" in "Health Sciences based upon life experiences and Stressology." In an ad for acupuncture from Parker College of Chiropractic, we observed that John L. Stump, DC, OMD, PhD also has his PhD from Columbia Pacific "U"niversity. Also in his letter, Dr. Aragona mentioned that CP"U" was in San Raphael, California, and provided the address. I lived a few

see "CREDENTIALS" on page 9

Credentials of One of the Members

A Bad Dream for the "Dream Team" and the Council on Chiropractic Practice:

About one and a half years ago, advertisements for a new technique, "Torque Release", began to appear in the mail and in Chiropractic trade journals. As time progressed, the originator of "Torque Release" technique added more and more accomplishments and awards to an already long list of degrees in the advertisements for the seminars, one of which featured the "Dream Team". The profession has the right to check on the awards and degrees listed in these advertisements.

We began to inquire about Dr. Holder's credentials from his 17-page resume prepared by him and submitted to a CCE institution and his advertisement claims. One "Dream Team" ad item was "Dr. Holder holds appointment to the faculty, Pharmacology, University of Miami,..." In August 1995, we received a reply from James D. Potter, PhD, Professor and Chairman of the Department of Molecular and Cellular Pharmacology at the University of Miami School of Medicine. He stated that (1) he had never heard of

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DREAM

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Dr. Jay Holder and (2) the University of Miami was **NOT** doing any research with him.

From this first shock of a possible total fabrication of research claimed in national advertisements, we began to discuss our suspicions with some colleagues, several of whom had begun doing their own looking into Dr. Holder's credentials. One of us had written to the medical school in Sri Lanka from which Dr. Holder claimed part of his MD degree was completed. Dr. Holder's resume lists "M.D.: CETEC Medical School Dominican Republic/OIU Medical School Columbo, S.L." We discovered that there is a Sri Lanka Medical Council. In an August 29, 1995 letter, Prof. P.S.S. Panditharatne, the registrar, told us the "OIU Medical School Columbo, S.L." listed in Dr. Holder's resume did **not** exist. One of us tried to track down the Medical School in the Dominican Republic from which he claimed to have attended. It had been closed for some time and records were hard to obtain, but it was not accredited anyhow.

A colleague determined that there was an "OIU" in Sri Lanka, but it is called the Open International University for complementary medicine, and it is not an accredited Medical School. "Prof. Dr. 'Sir' Anton Jayasuriya," who is chief rheumatologist and chief acupuncturist, teaches "Eastern Medicine (Acupuncture and Qigong)" in a four day seminar (fee $550-US) called "Better Medicine Education". The seminar is mostly Acupuncture in content. For an additional fee of $400-US, outstanding students are awarded an M.D. (which is their abbreviation for Masters Degree) or other degrees such as B.Science, or extra credentials. Seminars have been held in (at least) Australia and Spain. The "Sir" in front of Anton Jayasuriya looked like a connection for "Sir" Jay Holder.

A further inquiry of the "Better Medicine Education seminar" resulted in a FAX back to us from Mandy Chen, convener. We were told that "OIU" has additional prizes such as "the Albert Schweitzer Award and Knighthood" (for an additional fee of $400-US). Now we had the "tie in" between Dr. Holder's alleged MD, Albert Schweitzer award, and his knighthood.

Our earlier correspondence with Prof. P.S.S. Panditharatne of Sri Lanka indicated that "OIU" was not an accredited Medical School, and now we found out that it is a four-day seminar. We obtained a copy of Dr. Holder's Albert Schweitzer Award. It was signed by Dr. Sir Anton Jayasuriya of "OIU". We called the "real" Albert Schweitzer Foundation in Boston. They do not give an award in medicine, in fact they do not give awards at all. We called the British Embassy. Dr. Holder has never been knighted. We wrote to the Souveraner Malteser-Ritter-Orden of Knights in Austria. In a letter dated 9-15-95, Johann Aehrenthal wrote that Jay M. Holder "is not a member."

From his resume, Dr. Holder's "PhD" is from the Anglo-American Institute in Bournemouth, England. The diploma reads "Anglo-American Institute of Drugless Therapy" (AAIDT). Neither the Bournemouth Press Library nor the Bournemouth police ever heard of it. Neither did the British Department of Education, the British Department of Higher Education, nor the London University Senate House. Finally, the Homeopathic Medicine Society informed us that AAIDT was a correspondence diploma mill, was not accredited, and has been closed. Unlike California, the British system does not allow unaccredited institutions to grant degrees.

It was discovered that Jay M. Holder is actually Jack M. Holder. An academic colleague contacted Dr. Blum (University of Texas), who is the legitimate originator of the Brain Reward Cascade theory used in Dr. Holder's advertisements. Dr. Blum stated that his theory and paper submitted to the Journal of Psychoactive Drugs has no evidence that subluxation or chiropractic is linked to the Brain Reward Cascade. This is contrary to claims made by Dr. Holder in his national advertisements.

We contacted Life College administrators. In a letter, Dr. Braile refused to look into "the accomplishments of a member of our post-grad Faculty."

After reading our findings, one could say that the "torque" (twisted story) has been released (pun intended)! Many DCs should have some egg on their faces, including DCs who paid to attend the seminars and college administrators who approved them without checking on the credentials of the presenters. We have some suggestions for Chiropractic Colleges and CCE. Resume items that should be checked are: 1) Foreign degrees, 2) PhD without prior mention of Bachelors and Masters degrees, 3) advanced degrees listed without the year, major, and exact institution of graduation, 4) long lists of awards and fellowships, and 5) awards that do not exist.

All information in this article is based upon facts filed at our office. Dr. Holder was given the opportunity to submit supporting documents for his degrees and awards but he declined.

ACCREDITATION

continued from front

fraudulent. Especially disturbing is the lack of "credential checking" of postgraduate faculty by Chiropractic Colleges. Chiropractic Colleges send out seminar flyers nationally on CCE approved seminars for license renewal with false information provided by the speakers concerning their accomplishments and degrees. Why aren't these "accomplishments" and "degrees" investigated for validity? Also, DCs are claiming to have PhDs (and/MDs) when in fact, these degrees are from unaccredited "universities." Why don't Chiropractic State Boards have policies on using only accredited degrees in other fields? The public is being misled by the false credentials of DCs who claim advanced degrees from unaccredited colleges and universities. We submit two examples as to why Chiropractic Colleges and State Boards should check on degrees and accomplishments claimed by DCs.

(see the two front page stories directly underneath the beginning of this article)

CREDENTIALS

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miles from San Raphael for seven years and never heard of CP"U", so I asked my wife to request an "Admissions Bulletin and Application" catalogue from CP"U".

She filled out the admission application and paid her fee. My wife, Dr. Sang Harrison, has an AA degree from Delaware Technical Community College and a DC from Life Chiropractic College. She has ***neither*** a Bachelors degree ***nor*** a Masters degree. She filled out the CP"U" application truthfully. In two weeks, she received notice from CP"U" that she had been accepted as a graduate student to work on a PhD in "Spinal Biomechanics" and had been awarded the equivalent of a Bachelors, Masters, and ***31 semester hours towards her PhD!*** I told her that in two weeks she was further along in her PhD studies than I was after 2.5 years at the University of Alabama in Huntsville, and I already had a BS and MS degrees in mathematics before I started there!! She was told that all she had to do was: (1) sign up for a total of four courses, (2) write her thesis on the topic of her choice, (3) pay approximately $1,100 for each of 4 quarters, and she should have her PhD in 9 to 12 months!

From CP"U"'s catalogue, we note that CP"U" assigns "credit for relevant educational work experience" and has the same four course curriculum whether you work on a Bachelors, Masters, or PhD. Dr. Sang had worked for seven years as a Lab Tech in hospitals and for a well known private Lab. The CP"U" core curriculum consists of four courses: (1) "Materials and Methods-Research in Information Resources and Developing a Learning Plan," (2) "Directed References and Readings-Expanding and Integrating Perspectives," (3) "Lifestyle and Environment-Personal; Choices and Goals, and Wellness," and (4) "Independent Study: Foundational Competence for Lifelong Learning-The Versatile Independent Scholar."

Now I don't know about you, but to me, these four courses do not seem to contain graduate course information in "Spinal Biomechanics" and "Health Sciences!" These Chiropractors submitted their technique texts as their thesis. I wonder if any PhD in Biomechanics or Psychology at a major university would think these two texts are publishable in an Index Medicus journal? It is a requirement at most universities that the PhD thesis be publishable in a peer reviewed journal in the field of study.

The existence of CP"U" is due to a quirk in California law which allows a license to grant a degree to nontraditional learning institutions even though they are not accredited. All an institution has to do in California is pay a license fee, prove that at least 3 areas of study are provided (one of CP"U"'s areas is Health Sciences!) and have a minimum number of degree faculty. It is interesting that 15% of CP"U" faculty have their PhDs from CP"U". I believe that it is morally wrong for a DC to add the PhD from an unaccredited institution to his/her credentials because this act misleads the public, who believe that such a degree is equivalent to a PhD from an accredited university. To stop the public from being misled by the unaccredited extra education of DCs, the Chiropractic State Boards should mandate that unaccredited degrees can not be advertised, added to office stationery, or exhibited in the DC's office.

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Scope of Practice Limitations on Unconventional Providers

The Case of Chiropractic

Michael H. Cohen, Esq.

State medical practice acts typically grant medical doctors so-called unlimited licensure, which entails the authority to *diagnose* and *treat* disease and to *prescribe* medication. On the other hand, statutes authorizing nonmedical alternative and complementary providers to practice typically grant so-called limited licensure. That is, the statutes authorize providers to offer services within a specifically designated *scope of practice*, but providers can neither diagnose nor treat disease nor prescribe medication in the broad sense of the medical practice acts.

Unfortunately, the boundaries are rarely clear. The question providers regularly face is whether, in assessing a particular patient or providing a specific therapy, they are acting within the scope of practice or moving beyond their legislative authorization and into the practice of medicine. Scope of practice issues become particularly acute as providers continue to explore new therapeutic techniques and as the health care industry places increasing emphasis on healing modalities outside conventional medical practice.[1]

To date, neither legislatures, courts, nor legal scholars have addressed this question adequately. This article attempts to set out some preliminary guidance for those confronting scope of practice limitations. For clarity, I focus on the profession of chiropractic. Chiropractic provides a good example of scope of practice issues because although chiropractors have well-established licensure in every state, many include a broad range of therapeutic techniques in their practice that test the scope of their licensure. Naturopaths, massage therapists, acupuncturists, and other providers may incorporate the following, as applicable, to their own professional practices.

Limits of Statutory Authorization

Judicial interpretation. Scope of practice limitations have a sound regulatory purpose: to ensure that providers offer services according to their skill and training and do not induce overreliance by patients on nonmedical therapies for a cure. For example, chiropractic training focuses on the impact of the nervous system and spinal health on overall well-being. Thus, chiropractic treatment may facilitate the individual's return to wholeness through manipulation, but a patient with a life-threatening illness should not be permitted to rely on that treatment to cure the disease.

For this reason, even if the licensing statute seems—from the chiropractor's perspective—to be broad enough to encompass the practice in question, courts sometimes err on the side of finding scope of practice violations rather than finding practitioners innocent of such violations. That is, courts interpret scope of practice limitations through a strong lens of consumer protection. Courts to date have not embraced holistic notions of health, in which providers are viewed as healing persons, not healing abstracted spines, muscles, or meridians. Because the prevailing legal paradigm describes scope of practice in terms of function (e.g., the notion that only medical doctors diagnose and treat patients, whereas chiropractors deal solely with spinal alignment), judicial decisions sometimes enforce rather arbitrary boundaries between the professions.

Statutory language/legislative intent. Providers and their attorneys should begin by examining the plain language of the authorizing statute. For example, Delaware defines chiropractic as the "science of locating and removing any interference with the transmission of nerve energy."[2] Iowa authorizes chiropractors to "treat human ailments by adjustment of the neuromusculoskeletal structures, primarily, by hand or instrument, through spinal care."[3] North Carolina authorizes chiropractors to "adjus[t] the cause of disease by realigning the spine, releasing pressure on nerves radiating from the spine to all parts of the body, and allowing the nerves to carry their full quota of health current (nerve energy) from the brain to all parts of the body."[4]

Thus, although every state licenses chiropractors, each state has its own statutory definition. The definitions vary in breadth and focus. Some statutory definitions, such as Iowa's, emphasize the chiropractor's use of spinal manipulation and adjustment. Other statutes, such as Delaware's, make references to more ambiguous concepts, such as location and removal of interference with "the transmission of nerve energy."

Courts to date have not embraced holistic notions of health.

The different kinds of authorizing language cause considerable confusion in interpreting the scope of chiropractic practice, particularly when providers move beyond spinal manipulation and into such areas as nutritional guidance, acupuncture, colonic irrigation, and energy healing. In a statute such as Delaware's, for example, chiropractors can make the argument that although a particular practice does not entail spinal manipulation, it does facilitate the free flow of nerve energy, which is an integral part of chiropractic practice. In a statute such as Iowa's, chiropractors might argue that language authorizing them to "treat human ailments" allows them to address a broad range of conditions and use a diverse range of healing modalities. On the other hand, courts may be unimpressed with these arguments and, based on the consumer protection argument and statutory references to "adjustment," limit chiropractors to assessment and manipulation of the spine.

Chiropractic and Nutritional Guidance

To take one important example, when a chiropractor provides nutritional guidance, has the chiropractor exceeded the scope of chiropractic practice and "prescribed," in violation of the medical practice acts?

Courts interpreting the authorizing statute first will examine the plain language and then the legislative history to determine whether the legislature intended to authorize the particular practice. Thus, the chiropractic licensing statute or the legislative history may expressly and unambiguously include or exclude the practice in question. Even if the practice is included, however, providers must examine the statute for limitations or restrictions in the authorizing language. For example, Iowa permits "rendering nutritional advice" but prohibits a chiropractor from "profit from the sale of nutritional products coinciding with the nutritional advice rendered."[3] West Virginia's chiropractic licensing statute does not expressly authorize nutritional guidance but provides that "[p]atient care and management is conducted with due regard for environmental and nutritional factors."[5]

Moreover, the statute may authorize the practice but contain a hidden or implicit restriction. For instance, Louisiana provides that a chiropractor "may also make recommendations relative to the personal hygiene and proper nutritional practices for the rehabilitation of the patient,"[6] whereas Massachusetts permits "dietary and nutritional advice, as treatment supplemental to a chiropractic adjustment."[7] In each case, the chiropractor's ability to provide clients with nutritional guidance is qualified. The chiropractor may recommend nutritional support only to the extent that this will help in the patient's "rehabilitation" or supplement the chiropractic work, respectively. Presumably, the nutritional advice cannot cross the line into medical treatment. It must be closely related to the chiropractic work, although where the line lies is unclear.

For example, in *Stockwell v. Washington State Chiropractic Disciplinary Board*, a chiropractor challenged the result of a disciplinary action sanctioning him (among other things) for selling or dispensing vitamins.[8] The relevant licensing statute did in fact authorize chiropractors to give "dietary advice." The court, nonetheless, held that mere advice differed from prescribing vitamins to treat disease. The court did not clarify the difference between "advice" and "prescription" and, in fact, did acknowledge that the recommended vitamins and food supplements were commonly available in retail stores. The court simply observed that these items presented "great potential for abuse" when prescribed to treat disease.[8]

Other courts similarly have found chiropractors who recommended vitamins and food supplements to their clients to have engaged in the unlicensed practice of medicine.[9] One court even found that vitamins, minerals, and food supplements were "drugs" within the meaning of the medical practice act, since they were recommended to treat disease.[10] In upholding chiropractors' convictions, such courts seem to rely on the rationale that the legislature did not intend to extend chiropractic beyond "existing statutory authorization to adjust the articulation of the human body according to specific chiropractic methods."[11] This harkens back to the notion of nonmedical providers as having a significantly limited scope of practice, compared with that of the medical doctor.

In short, where statutes are silent as to whether chiropractors can offer nutrition-

Generally, providers cannot practice a healing modality that is subject to separate licensure unless specifically authorized by their licensing statutes to do so.

al guidance and courts have not ruled, providers should exercise caution. They may wish to seek an advisory opinion from the state attorney general. Otherwise, they risk prosecution for violating their scope of practice.

Other Practices by Chiropractors

Colonic irrigation. As with nutritional care, statutes vary regarding chiropractors' inclusion of practices such as colonic irrigation. Some statutes expressly prohibit chiropractors from performing colonic irrigation,[12,13] whereas others permit inclusion of the practice.[14] Some jurisdictions, such as Washington, D.C., require additional certification for chiropractors desiring to include "counseling about hygienic and other noninvasive ancillary procedures."[15]

Acupuncture. Generally, providers cannot practice a healing modality that is subject to separate licensure unless specifically authorized by their licensing statutes to do so. For example, chiropractors cannot practice acupuncture or social work and counseling, each of which is separately licensed in most states, unless specifically authorized by the chiropractic licensing statute. Nor can providers simply practice any modalities, licensed or otherwise, by obtaining an ordinary business license from the state.

Two states expressly permit chiropractors to include the practice of acupuncture,[16,17] whereas two others prohibit the practice.[18,19] Other state statutes are silent.*

Some courts have held that acupuncture constitutes the practice of surgery and, hence, is forbidden to chiropractors under medical practice acts.[20,21] Others have concluded that acupuncture is not surgery.[22] In *Commonwealth v. Schatzberg*,[23] a Pennsylvania court upheld a regulation by the State Board of Chiropractic Examiners, promulgated pursuant to advice from the state attorney general, which stated that the practice of acupuncture was not within chiropractors' scope of practice. Chiropractic, according to the court, is "limited" to "the relationship between...the nervous system...[and] misaligned or dislocated vertebrae or articulations."[23]

Physical examination. The view of chiropractic as limited to spinal manipulation tends to dominate judicial interpretations of licensing statutes even when the challenged act appears to be an integral part of responsible practice. For example, in *State v. Beno*, the Michigan Supreme Court held that the scope of chiropractic does not include a general physical examination of a patient complaining of low back pain and a sore elbow.[24] The defendant chiropractor argued that chiropractors were, in fact, authorized to "diagnose an elbow ailment to determine whether the cause is local (i.e., originates in the elbow area) or results from nerve interference created by spinal subluxations or misalignments."[24]

The attorney general argued that "the treatment of or attempt to treat an extremity falls outside the statutory authority of a chiropractor and constitutes the practice of medicine."[24] The attorney general further argued that a chiropractor was limited to using x-rays to locate spinal subluxations or misaligned spinal vertebrae and that a chiropractor who wanted to rule out a localized problem had to refer the patient to a physician.

The hearing officer concluded that "x-ray of an elbow is outside the scope of chiropractic," since the "statute is clear and it stretches logic as to how the x-ray of a right elbow is any way encompassed by" the statutory authorization.[24] The trial court, affirming, found that "it *stretches credibility to conclude that the* elbow is so related to the spine that spinal subluxations or misalignments may produce nerve interference in the elbow. The logic of this position would extend chiropractic through the entire body and even the brain!"[24]

The Michigan Court of Appeals accepted the chiropractor's view that "nerve interference efferent [from] the spinal column may produce symptoms in other parts of the body."[24] However, the Michigan Supreme Court, reversing, acknowledged the "hazy line between the jurisdiction of the health care professions" but emphasized its duty to interpret the law so as to secure "protection of the health, safety, and welfare of the peo-

*For more information regarding state acupuncture laws, write to the National Acupuncture Foundation, 1718 M Street, Suite 195, Washington, DC 20036, (202) 332-5794, to obtain *Acupuncture and Oriental Medicine Laws* by Barbara B. Mitchell, Esq. (1995).

Providers face greater risk if they make nutritional recommendations for acute, chronic, or life-threatening conditions, such as diabetes or cancer.

ple of this state."[24] The court adopted the view that the chiropractor was *not authorized to "examine the elbow* to determine if there is nerve interference," since "the existence of a spinal subluxation or misalignment cannot be observed by examining areas away from the spine that may be experiencing the pain of nerve interference"[24] [emphasis added]. The court reasoned that giving chiropractors such diagnostic authority could mislead the patient that a definitive diagnosis as to nonspinal injuries had been made, particularly in light of the chiropractor's testimony that "we must look wholistically, at the entire body."[24]

The *State v. Beno* decision is rather extreme in prohibiting the chiropractor from even examining the patient's elbow to determine whether referral to a medical doctor is appropriate. The prosecution, hearing officer, trial judge, and supreme court in *State v. Beno* viewed chiropractic as limited to the spine, which in the current legal paradigm is somehow seen as disconnected from the rest of the body.†

Diagnostic Procedures

In some states, chiropractors are expressly authorized to take x-rays,[25–27] conduct urine analysis,[28] take or order blood tests and other routine laboratory tests,[3] or perform physical examinations.[3] Many other state statutes are silent, leaving providers who perform such procedures at risk of prosecution for the unlicensed practice of medicine.

Suggestions for Providers

For particular legal advice, providers should consult attorneys in their jurisdiction. The following general suggestions may help mitigate some of the legal risks relating to scope of practice.

1. Check express authorization. Providers should proceed cautiously when including therapies or procedures that may exceed their express statutory authorization. Specifically, providers should consult with their attorneys, professional organizations, and appropriate state regulatory bodies (such as the Board of Chiropractic Examiners) regarding the use of procedures and therapies, such as nutritional support, colonic hydrotherapy, acupuncture, diagnostic tests, and physical examinations.

2. Give conservative nutritional guidance. Because the line between dietary advice or guidance and treatment is blurry, chiropractors and other providers should check decisions under applicable medical practice acts and their own licensing statutes. Selling dietary substances directly may be prohibited. Recommending nutritional changes to patients may be viewed as crossing the line into prescribing or treating under the medical practice acts.

Providers are on safer ground when they recommend nutritional products for conditions relating to their authorized practice—for example, chiropractors recommending B-complex vitamins to strengthen the nervous system. On the other hand, providers face greater risk if they make nutritional recommendations for acute, chronic, or life-threatening conditions, such as diabetes or cancer.

3. Avoid exaggerated claims. Providers need to be clear that they are providing services within their scope of practice, particularly with patients who have serious or life-threatening diseases. For

To avoid scope of practice problems, providers should:

1. Consult with their attorneys, professional organizations, and applicable state regulatory boards regarding the use of nutritional guidance, colonic hydrotherapy, acupuncture, and other practices not expressly authorized by statute.
2. Unless clearly authorized, consider limiting nutritional guidance to avoid crossing the line into "prescribing" or "treating."
3. Avoid claims and promises regarding results of a particular therapy or session to avoid misrepresentation claims and malpractice liability based on medical standards.
4. Maintain appropriate consent forms so as to honor scope of practice boundaries and clarify patients' expectations.
5. Be clear about when patients require referral to M.D.s in order to meet any applicable duty to refer.

†I challenge this paradigm in a longer article, "Holistic Health Care: Including Alternative and Complementary Medicine in Insurance and Regulatory Schemes," to be published by the *Arizona Law Review* in March 1996.

When the condition plainly is outside the practitioner's expertise and training, the practitioner is held to a medical standard of care for purposes of malpractice liability.

example, the chiropractor could say, "I am adjusting your spine to restore the flow of nerve energy, which will support your overall well being." On the other hand, telling the patient "this adjustment will mitigate your cancer" is inadvisable.

Providers should avoid claims and promises regarding results of a particular therapy or session so as to avoid liability for misrepresentation and malpractice. For example, a chiropractor may be liable for misrepresentation in claiming that chiropractic can cure or even help diabetes.[29] When the condition plainly is outside the practitioner's expertise and training, the practitioner is held to a medical standard of care for purposes of malpractice liability.[29]

4. Provide clear informed consent forms. Providers should have their patients sign informed consent forms, which explain that the particular provider is not an M.D. and does not diagnose and treat disease. The form should advise the patient to consult a licensed physician for diagnosis and treatment of any medical condition. The form also should state what the provider is legally authorized to do—for example, in Delaware, "locating and removing any interference with the transmission of nerve energy."[2] Informed consent forms can help providers be clear about the risks and benefits of particular therapies. By disclosing risks ahead of time, without exaggerating promises of cure, providers minimize the risk of client misunderstanding based on inflated expectations.

5. Know when to refer. Many courts may impose on chiropractors a duty of reasonable care in the analysis and treatment of their patients, which includes the duty to: (1) determine whether the patient presents a problem that is treatable through chiropractic; (2) refrain from further chiropractic treatment when a reasonable chiropractor should be aware that the patient's condition will not be responsive to further treatment; and (3) if the problem is outside the chiropractor's skill, training, and expertise, inform the patient that the condition is not treatable through chiropractic.[30] In some states, the latter requirement involves a duty to refer the patient to medical care.[31]

A chiropractor who negligently fails to inform the patient that the condition is not one amenable to chiropractic treatment—or, in some states, to refer the patient in such cases to a medical doctor, may be liable for malpractice.[32] In many states, the oath administered to chiropractors by the state licensing board requires referral to medical doctors when the patient's problem exceeds the limits of chiropractic care.[33] Such an oath may be admitted into evidence to show the standard of chiropractic care and possible violation.[33]

Conclusion

Ultimately, providers may wish to lobby legislatures to include specific therapies in the applicable licensing statutes. However, many novel practices still may emerge that elude or defy definition. Ultimately, providers must continue the effort of educating medical, scientific, and legal communities that chiropractic, massage therapy, and other disciplines, although not unlimited, may have more expansive healing potential than previously has been recognized. □

Acknowledgments

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(213) 656-2652

Aug. 21, 1995

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Lastly, if you would be so kind to provide me with the address of the American Board of Osteopathic Specialties, it would be greatly appreciated.

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Thaddeus E. Kelly, M.D., Ph.D.

Joann A. Boughman, Ph.D. (alternate)
John C. Carey, M.D. (alternate)

MISSION STATEMENT OF THE AMERICAN BOARD OF MEDICAL SPECIALTIES

The American Board of Medical Specialties (ABMS) is an organization of approved medical specialty boards. The mission of the ABMS is to maintain and improve the quality of medical care by assisting the Member Boards in their efforts to develop and utilize professional and educational standards for the evaluation and certification of physician specialists. The intent of the certification of physicians is to provide assurance to the public that a physician specialist certified by a Member Board of ABMS has successfully completed an approved educational program and an evaluation process which includes an examination designed to assess the knowledge, skills, and experience required to provide quality patient care in that specialty. The ABMS serves to coordinate the activities of its Member Boards and to provide information to the public, the government, the profession and its members concerning issues involving specialization and certification in medicine.

PURPOSES OF THE AMERICAN BOARD OF MEDICAL SPECIALTIES

In fulfilling its mission, the ABMS shall, as the coordinating body, be organized to fulfill the following purposes:

1. Participate in the establishment of standards and requirements for Graduate Medical Education in the respective specialties and subspecialties represented by the Member Boards.
2. Ensure all Member Boards establish and maintain standards for the administration of examinations for certification.
3. Set standards for, receive, and act upon applications from Member Boards for approval of new types of certification, modification of existing types of certification, and related matters.
4. Ensure all Boards establish criteria and approve standards endorsed by all Boards for admission of candidates to the certifying examinations.
5. Encourage research in methods of education, evaluation, and examination leading to certification.
6. Coordinate activities of the Member Medical Specialty Boards with the aim of avoiding duplication of effort and to prevent or resolve problems encountered among and between the Member Boards.
7. Receive and act upon applications for membership by proposed new specialty boards.
8. Serve as a central registry for the public dissemination of information about the certification status of all those individuals certified by the Member Boards.
9. Represent the Member Boards in communication with other groups or agencies or individuals, public or private, with respect to matters of common interest to the members.
10. Exchange information among Member Boards and any other organizations that will enhance the goals, quality, and efficiency of the Member Boards.
11. Serve as a forum for discussion among Member Boards and other health care organizations about the education, evaluation, and certification of physician specialists.
12. Conduct educational programs designed to make information about the board certification process and the certification status of physician specialists readily available to the public and throughout the profession in an easily understood manner.
13. Monitor issues and establish liaison with organizations involved in graduate medical education and evaluation of physician competence, where appropriate, and distribute information about graduate medical education and the evaluation of physician competence to the members of ABMS.

NATURE AND FUNCTION OF SPECIALTY BOARDS

The primary objective of specialty boards is the improvement of the quality of medical education and medical care.

The primary function of each of the specialty boards is to evaluate candidates in its field who voluntarily appear for examination and to certify as diplomates those who are qualified. To accomplish this function, specialty boards determine whether candidates have received adequate preparation in accordance with established educational standards, provide comprehensive examinations to evaluate such candidates, and certify those who have satisfied the requirements.

In collaboration with other organizations and agencies concerned, the approved specialty boards assist in improving the quality of medical education by elevating the standards of graduate medical education and approving facilities for specialty training.

The actual accreditation review for the approval of residency training programs in each specialty is conducted by a Residency Review Committee (RRC) on which the respective Specialty Board has equal representation with the AMA Council on Medical Education and, in some cases, with a related specialty society.

The governing body of each individual Specialty Board is comprised of specialists qualified in the particular field represented by that board. Members of the governing bodies are derived from the several national specialty organizations in related fields and related sections of the AMA. Specialty Boards endeavor to maintain appropriate representation of specialists according to:

- geographic distribution
- type of practice and academic relationships
- qualification in the appropriate subspecialties
- demonstrated motivation and ability to assist in the evaluation procedures leading to certification

The Directory of Member Boards provides the following information about each Regular Member of the ABMS:

- name, mailing address, and telephone number
- sponsoring, nominating, or constituent organizations
- administrative officer(s) and mailing address(es)
- names and locations of officers, members, trustees, and board of directors

Summary **Tables of Information** supply Board Certification, Recertification and other aggregated data:

Table 1. General and subspecialty certificates approved by ABMS and issued by Member Boards, including date of approval and date of first issue.

Table 2. The number of physicians certified annually in each general specialty for the previous decade and totals.

Table 3. Identifies some of the specific requirements for general certificates issued by each specialty board.

Table 4. The number of physicians certified in each subspecialty certificate issued for the past decade.

Table 5. A listing, by specialty, of self-assessment and in-training programs offered.

Table 6. Identifies some of the specific requirements for recertification by each specialty board.

Table 7. A tabulation of board certified specialists by geographic distribution and specialty.

AMERICAN BOARD OF MEDICAL SPECIALTIES

Organization

The American Board of Medical Specialties is incorporated in the State of Illinois as a not-for-profit corporation classified for income tax purposes by the Internal Revenue Service under Section 501(c)(6) of the Internal Revenue Code.

The individual organizations comprising the membership of the ABMS are classified as either Regular Members (often referred to as Member Boards) or Associate Members. The Regular Members (Table 1) include 23 Primary Boards and one Conjoint Board. The Associate Members are six national organizations concerned with graduate medical education and specialty practice, but they are not specialty boards. All Members pay dues and have voting rights; voting representatives are eligible to hold office and serve on committees.

The Bylaws provide for representation of the public by three Public Members who may vote and serve on committees but who do not pay dues or hold office.

Officers

The officers consist of the President, the President-Elect or Vice President, the Treasurer, and the Secretary. The office of Secretary is held by the Executive Vice President.

Executive Committee

The Executive Committee consists of the President, the President-Elect or Vice President, and the Treasurer. Six members, who are not officers, are elected at large from the voting representatives. The Executive Committee also includes the Secretary (ex officio, without the right to vote) and the Chairman of COBEX.

Voting Representatives

All Regular Members designate voting representatives, the number being based proportionately on the number of general certificates issued during the preceding five years, but no Regular Member has less than two voting representatives. Each Associate Member has one voting representative. Members are entitled to name alternate voting representatives.

Assembly

The Assembly is the final decision-making authority of the ABMS and is composed of the Voting Representatives of all Regular Members, Associate Members and Public Members. All the members of the Executive Committee are ex officio of the Assembly without vote. The President shall be the presiding officer over all meetings of the Assembly and the Secretary shall be responsible for giving notice of all meetings and recording all actions taken by the Assembly.

Public Members

To provide advice on decisions affecting the public, the Executive Committee appoints as many as three Public Members who are experienced persons with no direct relationship to any certifying board or the certification process. Each Public Member has one vote.

Budget

The ABMS is primarily funded by dues paid annually by Regular Members. The basis for these dues is the number of general certificates issued during the calendar year. Dues are also paid by Associate Members and are on a per annum basis. The annual budget of the ABMS supports the service functions of the central office, the expenses of the organizational units and committees, as well as the costs of participating in the activities of the Council for Medical Affairs, the Accreditation Council for Graduate Medical Education, the Accreditation Council for Continuing Medical Education and other relevant organizations.

Committee Structure

The ABMS conducts much of its work through committees that report, via the Executive Committee, to the voting representatives at the Annual and Interim Meetings. The following standing committees conduct assignments as delegated by the Executive Committee:

Nominating Committee
Finance Committee
Bylaws Committee
Committee of Board Executives
Committee on Certification, Subcertification, and Recertification
Committee on Study of Evaluation Procedures
Committee on Graduate Medical Education

As the need arises, the Executive Committee also creates ad hoc committees and task forces to consider and report on specific issues.

The ABMS also formally participates in several liaison committees such as the Liaison Committee for Specialty Boards, the Council for Medical Affairs, the Accreditation Council for Graduate Medical Education, and the Accreditation Council for Continuing Medical Education.

Meetings

The ABMS conducts business meetings twice a year—an Annual Meeting held in March and an Interim Meeting held in September. In addition, the administrative officers of the Member Boards (Committee of Board Executives) usually hold two meetings annually. Other meetings are called from time to time that include either the entire voting membership or limited groups representing Members.

Staff

The full-time professional staff of the ABMS includes an Executive Vice President, an Associate Vice President, a Director of Evaluation and Education, a Director of Operations, and a Director of Publications.

PROGRAMS AND ACTIVITIES

Specialty Biographical Directories

Since the 1940's a directory listing individuals certified by ABMS Member Boards has been published. This was accomplished through a cooperative venture with Marquis Who's Who publishers. In 1986, ABMS published the first edition of the ABMS COMPENDIUM OF CERTIFIED MEDICAL SPECIALISTS. In 1992, the COMPENDIUM was renamed the *Official* ABMS DIRECTORY OF BOARD CERTIFIED MEDICAL SPECIALISTS. From 1983 to 1992, ABMS also published four editions each of 24 individual specialty directories.

In 1992, discussions with Marquis Who's Who/Reed Reference Publishing were begun with a goal to combine the ABMS DIRECTORY and the *Directory of Medical Specialists*. This goal was realized in 1993 with publication by Marquis Who's Who of both the comprehensive and individual directories. The *Official* ABMS DIRECTORY OF BOARD CERTIFIED MEDICAL SPECIALISTS, previously published biennially, is now published annually. All directories are available from Marquis Who's Who, 121 Chanlon Road, New Providence, NJ 07974 (1-800-521-8110).

Books

In the Fall of 1982 the ABMS began publishing hardbound editions of the proceedings from ABMS conferences on topics relating to medical specialty certification and the evaluation of medical competence. The titles of these volumes are listed below with their respective dates of publication.

Evaluation of Noncognitive Skills and Clinical Performance (9/82)
Evaluating the Skills of Medical Specialists (7/83)
Oral Examinations in Medical Specialty Board Certification (9/83)
Legal Aspects of Certification and Accreditation (11/83)
Computer Applications in the Evaluation of Physician Competence (9/84)
Residency Director's Role in Specialty Certification (4/85)
Trends in Specialization: Tomorrow's Medicine (11/85)
Hospital Privileges and Specialty Medicine (4/86) (revised 1992)
How to Evaluate Residents (1/87)
Recertification for Medical Specialists (12/87)
How to Select Residents (4/88)
The ABMS Handbook on Board Certification and the Americans with Disabilities Act (8/92)
Health Policy Issues Affecting Graduate Medical Education (1992)
The Ecology of Graduate Medical Education (10/93)
Recertification: New Evaluation Methods and Strategies (4/94).

Further information about these volumes can be obtained directly from the ABMS.

Conferences

Since the early 1940s, the ABMS has sponsored conferences on topics relating to medical specialty certification and the evaluation of medical competence. These conferences have been a day to a day and a half in length and have usually been held in conjunction with Annual and Interim Meetings.

ABMS Record

For the dissemination of timely information, the ABMS publishes various editions of its newsletter, the *ABMS Record*. These are routinely mailed to ABMS officers, committee members, associate members, voting representatives, member boards and their directors and sponsoring organizations, and boards of medical examiners. Copies are available to others upon request.

The ABMS Record contains information about matters relating to medical specialty certification, activities of ABMS components and members, and meetings of related organizations that are attended by ABMS representatives. The ABMS Record is published six times a year.

Evaluation and Education News

The ABMS quarterly newsletter, *Evaluation and Education News*, was begun in 1993 as a service to Member Boards under the auspices of the ABMS Committee on Study of Evaluation Procedures (COSEP). The newsletter includes abstracts of recent publications, reports and commentary on certification, testing, and assessment of clinical competence of potential interest to the medical specialty certification community.

competence of potential interest to the medical specialty certification community.

HISTORY

The Forerunners

The growth of specialty medicine is directly linked to the advancements of medical science and the resulting vast improvements made in medical care delivery since the turn of the century. During this period of growth, there was no system to assure the public that a physician claiming to be a specialist was indeed so qualified. Until the development of the specialty board movement, each physician had been the sole assessor of his qualifications to practice a given specialty. Specialty societies and medical education institutions encouraged the development of boards to define specialty qualifications and to issue credentials that would assure the public of the specialist's qualifications. As the original boards and societies matured, it was only natural that they should coalesce and organize a national system to provide for the recognition of qualified physician specialists.

The concept of a specialty board was first proposed in 1908 by Dr. Derrick T. Vail in his presidential address to the American Academy of Ophthalmology and Otolaryngology. He stated:

> I hope to see the time when ophthalmology will be taught in this country as it should be taught. That day will come when we as oculists, demand that a certain amount of preliminary education and training be enforced before a man may be licensed to practice ophthalmology. It should no longer be possible for a man to be called an oculist, by himself or by the laity, after he has spent a month or six weeks in some postgraduate school or after serving as assistant for six months or a year in some oculist's office. After a sufficiently long time of service in an ophthalmic institution in America or abroad, he should be permitted to

appear before a proper examining board, similar to any State Board of Examination and Registration, for examination and if he is found competent let him then be permitted and licensed to practice ophthalmology.

After further consideration, and committee study by the American Ophthalmologic Society, recommendations were made for the development of a training and examination program. In 1915, a joint committee comprised of the American Ophthalmologic Society, the Section of Ophthalmology of the AMA, and the Academy of Ophthalmology drafted a report recommending the establishment of a board "to arrange, control and supervise examinations, to test the preparation of those who design to enter on the special or exclusive practice of ophthalmology." This report also recommended that:

> the board shall fix requirements to be met by all candidates for examination, which shall include the successful completion of a course in medicine in a medical school of recognized good standing, at least two years before examination; adequate study of ophthalmology and allied subjects; and payment of an examination fee to be fixed by the board. It shall be authorized to prepare lists of medical schools, hospitals, and private instructors recognized as competent to give the required instruction in ophthalmology.

This report was subsequently approved by each of the three represented organizations. The first meeting of the newly created American Board for Ophthalmic Examinations (the first specialty board) was held on May 8, 1916. The board was officially incorporated in 1917, and in 1933 its name was changed to the American Board of Ophthalmology. This Board established the guidelines for field training and evaluating candidates desiring to practice ophthalmology.

The second specialty board, the American Board of Otolaryngology, was founded and incorporated in 1924. This Board developed along the same path as its predecessor and, like many other boards that were eventually established in the 1930s, its original objectives were quite comprehensive:

> To elevate the standards of otolaryngology, to familiarize the public with its aims and ideals, to protect the public against irresponsible and unqualified practitioners, to receive applications for examinations in otolaryngology, to conduct examinations of such applicants, to issue certificates of qualification in otolaryngology and to perform such duties as will advance the cause of otolaryngology.

The third and fourth boards, the American Board of Obstetrics and Gynecology and the American Board of Dermatology and Syphilology, were establishd in 1930 and 1932, respectively.

On June 11, 1933 a conference was attended by representatives from the four specialty boards and the American Hospital Association, the Association of American Medical Colleges, the Federation of State Medical Boards, the AMA Council on Medical Education and Hospitals, and the National Board of Medical Examiners. It was resolved that:

> the examination and certification of specialists is best carried out by the National Boards (specialty boards)...; second, that the efficacy of these boards will be brought to their best level by the formation of an advisory committee or council created by two delegated representatives from the official specialty boards now in existence or in the process of formation and the other organizations at the meeting.

Thus was created the Advisory Board for Medical Specialties.

Development

Formal organization of the Advisory Board occurred at a meeting in Boston on September 20, 1933. Louis B. Wilson, M. D. became president; J. S. Rodman, M. D., vice-president; and Paul Titus, M. D., secretary-treasurer. The Constitution and Bylaws were adopted on February 11, 1934. Article II, Section I of the Bylaws stated the purpose of the organization as: "(1) to furnish an opportunity for the discussion of problems common to the various specialty examining boards in medicine and surgery; (2) to act in an advisory capacity to these boards; and (3) to coordinate their work as far as possible." Section II stated that the "Council (Advisory Board) shall assume jurisdiction over those policies and problems common to all of the Boards which are expressly delegated to it by the Component boards." Section III further stated that the Advisory Board "shall not interfere with the autonomy of any examining board having representation herein" and, in Section IV, the Advisory Board "is authorized to stimulate improvement in postgraduate medical education." Though broadened since then, these purposes and goals remain much the same today.

Since 1934, official recognition of specialty boards in medicine has been achieved by the collaborative efforts of the Advisory Board for Medical Specialties (and later by its successor, the American Board of Medical Specialties) and the AMA Council on Medical Education. In 1948, these efforts were formalized through the establishment of the Liaison Committee for Specialty Boards (LCSB) and the publication of the *Essentials for Approval of Examining Boards in Medical Specialties*. A jointly approved document, the *Essentials* established standards for the approval of the new specialty boards. This document has undergone several revisions through the years and remains the standard for recognition of new specialty boards.

By 1948, 14 new specialty boards had received approval, bringing the total number to 18. A revision of the Bylaws in 1961 recognized these new boards and also provided for the representation (though without voting privileges) of affiliate boards. Between 1949 and 1969 no new boards were approved by the LCSB.

In the next decade (1969-1979), the remaining five specialty boards (Allergy and Immunology, Emergency Medicine, Family Practice, Nuclear Medicine, and Thoracic Surgery) were approved, bringing the current total to 23 ABMS Member Boards.

From 1933 to 1970, the Advisory Board operated as a federation of individual specialty boards. Between the years 1943 and 1949 it met annually each February to discuss items of mutual concern, in addition to conducting conferences for the Member Boards and representatives of United States medical schools. The subject of the 1949 conference was *The Effects of the Specialty Boards on American Medicine*. At this time, the suggestion was first made to reorganize the Advisory Board and hire a full-time staff to better serve its constituency and the public, as the Advisory Board had functioned primarily as a forum for discussion without the benefit of a full-time director or a central office from which to conduct its daily operations. At the annual meeting of the Advisory Board on February 4, 1961, approval to incorporate was received and official incorporation of the Advisory Board was attained on March 21, 1961.

By 1969, effective efforts at reorganization had been instituted and a formal funding mechanism was established on the basis of a dues assessment for each diplomate certified by a primary, affiliate, or subsidiary board. On February 13, 1970, the membership voted to reorganize the Advisory Board as the American Board of Medical Specialties (ABMS). This change became official with the amendment of the Articles of Incorporation on April 10, 1970. July 1, 1970 marked the retirement of Louis A. Buie, M. D., of Rochester, Minnesota. Dr. Buie had served with distinction for 12 years as the part-time secretary-treasurer of the Advisory Board. A full-time executive director, John C. Nunemaker, M. D., was employed and the headquarters established in Evanston, Illinois.

PARENT ORGANIZATIONS OF THE CFMA, LCME, ACGME, AND ACCME
PARENT ORGANIZATIONS ESTABLISH POLICY

ABMS AMA AHA AAMC CMSS	AMA AAMC	ABMS AMA AHA AAMC CMSS	ABMS AMA AHA AAMC CMSS AHME FSMB
COUNCIL FOR MEDICAL AFFAIRS	LIAISON COMMITTEE ON MEDICAL EDUCATION	ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION	ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION
FUNCTION: Forum for discussion of issues relevant to medical education	FUNCTION: Accrediting M.D. Programs	FUNCTION: Accrediting GME Programs	FUNCTION: Accrediting CME Providers
REPRESENTATIVES Two senior elected officers and the Chief Executive Officer of: ABMS AMA AHA AAMC CMSS	REPRESENTATIVES AMA (6) AAMC (6) CACMS (1) Public (2) Participants (non-voting): Students (2) Federal (1)	REPRESENTATIVES ABMS (4) AMA (4) AHA (4) AAMC (4) CMSS (4) Resident Physicians Section AMA (1) Public (1) Federal (non-voting) (1) RRC Council Chrp (1)	REPRESENTATIVES ABMS (3) AMA (3) AHA (3) AAMC (3) CMSS (3) AHME (1) FSMB (1) Public (1) Federal (non-voting) (1)
CFMA Secretary P.O. Box 7586 Chicago, IL 60680	LCME Secretary (odd years) 515 N. State St. Chicago, IL 60610 (even years) 1 Dupont Circle N.W. Washington, D.C. 20036	ACGME Secretary 515 N. State St., Suite 2000 Chicago, IL 60610	ACCME Secretary Box 245 Lake Bluff, IL 60044

AAMC Association of American Medical Colleges
ABMS American Board of Medical Specialties
AHA American Hospital Association
AHME Association For Hospital Medical Education
AMA American Medical Association
CACMS Committee on Accreditation of Canadian Medical Schools
CMSS Council of Medical Specialty Societies
FSMB Federation of State Medical Boards

ABMS MEMBER SPECIALTY BOARDS

ALLERGY AND IMMUNOLOGY
American Board of Allergy and Immunology
University City Science Center
3624 Market Street
Philadelphia, PA 19104-2675
(215) 349-9466

ANESTHESIOLOGY
American Board of Anesthesiology
100 Constitution Plaza
Hartford, CT 06103-1796
(203) 522-9857

COLON & RECTAL SURGERY
American Board of Colon and Rectal Surgery
20600 Eureka Rd., Suite 713
Taylor, MI 48180
(313) 282-9400

DERMATOLOGY
American Board of Dermatology
Henry Ford Hospital
Detroit, MI 48202
(313) 874-1088

EMERGENCY MEDICINE
American Board of Emergency Medicine
3000 Coolidge Road
East Lansing, MI 48823
(517) 332-4800

FAMILY PRACTICE
American Board of Family Practice
2228 Young Drive
Lexington, KY 40505
(606) 269-5626

INTERNAL MEDICINE
American Board of Internal Medicine
University City Science Center
3624 Market Street
Philadelphia, PA 19104-2675
(215) 243-1500
(800) 441-ABIM

MEDICAL GENETICS
9650 Rockville Pike
Bethesda, MD 20814-3998
(301) 571-1825

NEUROLOGICAL SURGERY
American Board of Neurological Surgery
Smith Tower, Suite 2139
6550 Fannin Street
Houston, TX 77030-2701
(713) 790-6015

NUCLEAR MEDICINE
American Board of Nuclear Medicine
900 Veteran Ave., Room 12-200
Los Angeles, CA 90024-1786
(310) 825-6787

OBSTETRICS & GYNECOLOGY
American Board of Obstetrics & Gynecology
2915 Vine Street
Dallas, TX 75204
(214) 871-1619

OPHTHALMOLOGY
American Board of Ophthalmology
111 Presidential Blvd., Suite 241
Bala Cynwyd, PA 19004
(215) 664-1175

ORTHOPAEDIC SURGERY
American Board of Orthopaedic Surgery
400 Silver Cedar Court
Chapel Hill, NC 27514
(919) 929-7103

OTOLARYNGOLOGY
American Board of Otolaryngology
5615 Kirby Drive, Suite 936
Houston, TX 77005
(713) 528-6200

PATHOLOGY
American Board of Pathology
PO Box 25915
Tampa, FL 33622-5915
(813) 286-2444

PEDIATRICS
American Board of Pediatrics
111 Silver Cedar Court
Chapel Hill, NC 27514-1651
(919) 929-0461

PHYSICAL MEDICINE AND REHABILITATION
American Board of Physical Medicine and Rehabilitation
Suite 674, Norwest Center
21 First Street, S.W.
Rochester, MN 55902
(507) 282-1776

PLASTIC SURGERY
American Board of Plastic Surgery
Seven Penn Center, Suite 400
1635 Market Street
Philadelphia, PA 19103-2204
(215) 587-9322

PREVENTIVE MEDICINE
American Board of Preventive Medicine
9950 W. Lawrence Ave., Suite 106
Schiller Park, IL 60176
(708) 671-1750

PSYCHIATRY & NEUROLOGY
American Board of Psychiatry & Neurology
500 Lake Cook Road, Suite 335
Deerfield, IL 60015
(708) 945-7900

RADIOLOGY
American Board of Radiology
5255 E. Williams Circle, Suite 6800
Tucson, AZ 85711
(602) 790-2900

SURGERY
American Board of Surgery
1617 John F. Kennedy Blvd., Suite 860
Philadelphia, PA 19103-1847
(215) 568-4000

THORACIC SURGERY
American Board of Thoracic Surgery
One Rotary Center, Suite 803
Evanston, IL 60201
(708) 475-1520

UROLOGY
American Board of Urology
31700 Telegraph Road, Suite 150
Bingham Farms, MI 48025
(313) 646-9720

HANDBOOK OF THE **BUREAU OF OSTEOPATHIC SPECIALISTS**

American Osteopathic Association
Department of Educational Affairs
142 E. Ontario Street
Chicago, Illinois 60611

Revised, July, 1995

PREFACE

The Bureau of Osteopathic Specialists (hereinafter also referred to as the Bureau) was organized in 1939 as the Advisory Board for Osteopathic Specialists to meet the needs resulting from the growth of specialization in the osteopathic profession. It was thought at that time that there should be standardization of postdoctoral education and regulations for certification in the various specialties or fields of practice. Therefore, the Board of Trustees of the American Osteopathic Association, through its agency, the Advisory Board for Osteopathic Specialists, became the certifying body.

The certifying boards came into existence as follows:

American Osteopathic Board of Radiology	1939
American Osteopathic Board of Surgery	1940
American Osteopathic Board of Ophthalmology and Otorhinolaryngology	1940
American Osteopathic Board of Pediatrics	1940
American Osteopathic Board of Proctology	1941
American Osteopathic Board of Neurology and Psychiatry	1941
American Osteopathic Board of Internal Medicine	1942
American Osteopathic Board of Obstetrics and Gynecology	1942
American Osteopathic Board of Pathology	1943
American Osteopathic Board of Dermatology	1945
American Osteopathic Board of Rehabilitation Medicine	1954
American Osteopathic Board of Anesthesiology (formerly under the Board of Surgery)	1956
American Osteopathic Board of Family Physicians (formerly the American Osteopathic Board of General Practice, 1972-1993)	1972
American Osteopathic Board of Nuclear Medicine	1974
American Osteopathic Board of Special Proficiency in Osteopathic Manipulative Medicine (formerly the American Osteopathic Board on Fellowship of the American Academy of Osteopathy, 1977-1990)	1977
American Osteopathic Board of Orthopedic Surgery (formerly under the Board of Surgery)	1978
American Osteopathic Board of Emergency Medicine	1980
American Osteopathic Board of Preventive Medicine (formerly THE American Osteopathic Board of Public Health and Preventive Medicine, 1982-1983)	1982

Examination committees for certificates of competence and earned fellowships came into existence as follows:

Select Committee on certificate of competence of the American Osteopathic Academy of Sports Medicine	1989

In the early development of the various specialty groups in the osteopathic profession, the certifying boards not only served as examining bodies for their candidates, but also were responsible for the development of the various types of postdoctoral educational programs, including residencies, preceptorships and subspecialty residencies (formerly known as assistantships or fellowships).

Until 1948, the Advisory Board was the clearing house and the final agency for recommending directly to the AOA Board of Trustees regarding specialty education and certification of candidates. In December, 1948, the Committee on Accreditation of Postgraduate Training was established to evaluate training

programs in the specialties other than for hospital residencies. The Bureau of Hospitals had largely taken over the approval of residencies in the specialty fields existing at that time by 1943. In many instances, the Bureau of Hospitals actually set up the training regulations for residencies.

As the specialty organizations developed, the various specialty affiliates, beginning with the American College of Osteopathic Surgeons, became responsible for the development of educational formats in their specialty fields. At the present time, these specialty affiliates are responsible for educational programs through their evaluating committees, and the certifying boards are responsible for the examination of candidates for certification.

In January, 1968, the Committee on Postdoctoral Training (COPT) replaced the Bureau of Hospitals for purposes of approval of postdoctoral training. In 1993, the Committee was renamed the Council on Postdoctoral Training (COPT).

In March, 1989, the AOA Board of Trustees provided the Advisory Board with the authority to review the appropriate documents of any AOA specialty affiliate proposing a certificate of competence or an earned fellowship. In July, 1991, the Board of Trustees changed the terminology to "certificate of special recognition," and in July, 1992, to "certificate of added qualifications." In February, 1994, the term was modified to "certification of added qualifications." Thus, certificates of special recognition or competence are no longer issued.

In 1993, the Board of Trustees changed the name of body from the Advisory Board to the Bureau.

ARTICLE VII - BASIC DOCUMENTS

Section 1. - Certifying Boards and Specialty Affiliate Examination Committees

A. The basic documents of the certifying boards shall be the constitution, bylaws, and the regulations and requirements, compiled and issued by each certifying board in accordance with the AOA "Rules of Procedure for Certifying Boards" and the "Standard Constitution and Bylaws", and "Model Regulations and Requirements," as approved by the Bureau and the AOA Board of Trustees (see Handbook of the Bureau of Osteopathic Specialists and Appendices A, B, and C).

B. The basic documents of the specialty affiliates shall be the bylaws and regulations pertaining to certification of added qualifications, compiled and issued by each affiliate in accordance with the Handbook of the Bureau of Osteopathic Specialists.

C. The AOA Committee on Basic Documents of Affiliated Organizations shall review all recommendations concerning the basic documents of certifying boards and report its recommendations to the AOA Board of Trustees. (B-7/79)

Section 7. - Annual Registration: Fee and Requirements

A. Active Diplomates

1) AOA dues notices mailed to active diplomates shall include a charge of $50.00 for each of the certifying boards under which the diplomate holds a certificate(s), for the annual registration of the certificate(s). Fifteen dollars ($15.00) of this fee shall be forwarded by the AOA controller to the respective certifying board for continuation of their work. The remaining thirty-five dollars ($35.00) shall be retained by the AOA to cover costs for processing applications and other ancillary expenses incurred with keeping the certification registration up to date. (B-7/76) (B-3/90)

2) Membership cards for those who have paid the current certification registration fee are to designate what specialty(s) or field(s) of practice the diplomate has been certified in.

3) Physicians certified for the first time shall not be required to pay the annual certification registration fee during the fiscal year in which the Executive Committee of the Bureau approved their certification. They are to be billed for the fee beginning with the next fiscal year. (B-7/66)

B. Inactive Diplomates

1) Diplomates who are classified as inactive shall not be required to pay the annual certification registration fee. Inactive diplomates may retain the possession of their certificate(s) and their names shall appear in the official registry of certified physicians with a designation of inactive status. Inactive diplomates shall have their certification designated in their individual listing in the geographic section of the AOA Yearbook and Directory. A diplomate shall be classified as inactive for one of the following reasons:

a) The diplomate is permanently retired and not gainfully employed in any phase of professional activity, and his/her practice status designation in the AOA Yearbook and Directory so indicates.

b) The diplomate is unable to practice the specialty or field of practice in which he/she is certified because of health or age.

2) Upon notification from the AOA Membership Department, the secretary of the Bureau shall advise the certifying board when a diplomate's classification is changed from active to inactive, or vice versa.

C. Diplomates Holding More Than One Certificate

1) If the diplomate is certified in more than one specialty or field of practice under the same certifying board, only one annual certification registration fee shall be required.

2) If the diplomate is certified in more than one specialty or field of practice under different certifying boards, and elects to retain more than one certificate, an annual registration fee for each of the certifying boards under which certification is held shall be required. If the diplomate does not elect to retain more than one specialty or field of practice, the earliest certificate issued shall be automatically revoked.

Section 8. - Revocation and Reinstatement of Certificates

A. In order to maintain his/her certificate, a diplomate must:

1) Be a member of the American Osteopathic Association or the Canadian Osteopathic Association, and

2) Pay the annual certification registration fee, unless classified as inactive, and

3) Maintain a minimum of 150 hours of approved and documented AOA Continuing Medical Education credits within a three-year period, at least one-third of which shall be in their general specialty (Category I or II). (B-2/86)

B. In the event that a diplomate does not meet the above requirements, his/her certificate shall be automatically revoked and name shall be removed from the Certificate Register. The secretary of the Bureau shall notify the diplomate and the secretary of the appropriate certifying board of any such revocation.

C. A certifying board shall have the power to recommend to the Bureau the revocation of the certificate of any diplomate whose certificate was obtained by fraud or misrepresentation, who exploits the certificate, violates the AOA Code of Ethics or is otherwise disqualified. (B-1/71)

D. Reinstatement of a certificate which was revoked when the diplomate was dropped from AOA membership for nonpayment of dues, or for nonpayment of the annual registration fee, will be automatic upon reinstatement of the diplomate's AOA membership and/or payment of the registration fee.

E. Reinstatement of a certificate which has been revoked for any other reason than that stated in paragraph D. above, shall require compliance with the requirements of paragraph A. above, as well as approval of the appropriate certifying board and the Bureau.

F. If a physician requests reinstatement of his/her certificate in the same AOA fiscal year as the year in which the certification registration fee was not paid, the physician shall be required to pay the registration fee for that year, as well as for the current fiscal year.

APPENDIX B

STANDARD BYLAWS
OF
CERTIFYING BOARDS
OF THE
AMERICAN OSTEOPATHIC ASSOCIATION

ARTICLE I - DUTIES

The duties of the American Osteopathic Board of _____ are to:

1. Define the qualifications for and to serve as an advisory board for all applicants for certification in the specialty(s) (or fields of practice) of _____ and any other specialty or field of practice which may be assigned to its jurisdiction.

2. Determine, in accordance with the provisions of these Bylaws, the standards of education, formal training and practice required for certification in the specialty(s) (or field or practice) of_____ _____ and of any other specialty or field of practice which may be assigned to its jurisdiction, subject to the recommendation of the Bureau of Osteopathic Specialists (hereinafter "the Bureau") and the approval of the Board of Trustees of the American Osteopathic Association (AOA).

3. Establish procedures, in accordance with the provisions of these Bylaws for the conduct of examinations at least once a year.

4. File with the Bureau, at the time specified by the Bureau, its recommendations concerning each applicant for certification, together with any pertinent information required by the Bureau.

5. Provide and issue certificates in all fields assigned to this Board, in accordance with the provisions of these Bylaws.

6. Recommend to the Bureau the revocation of a certificate in accordance with the provisions of these Bylaws.

7. Record and keep permanently on file all applications submitted, complete records of examination results, and maintain a registry of diplomates.

8. Determine and collect the application and examination fees, in accordance with the provisions of these Bylaws and provide for the funds necessary to finance the operation of the Board.

9. Arrange for all meetings necessary for this Board to carry out its functions as provided for in these Bylaws.

10. Recommend a member of the Board to act as representative on the Bureau. In case of the inability of the regular representative to attend the sessions of the Bureau, an alternate shall be recommended, as provided in the AOA "Rules of Organization and Procedure of the Bureau for Osteopathic Specialists".

11. Conduct its activities in relation to the officers of the American Osteopathic Association, the Bureau, other certifying boards and applicants for certification, in accordance with the AOA "Rules of Procedure for Certifying Boards".

12. Establish, in conformance with the Constitution and Bylaws, all necessary rules and procedures governing the activities of the

Board which are not provided by the Bureau and the AOA Board of Trustees.

13. Report all recommendations regarding candidates for certification to the Bureau for approval, and all other actions, recommendations and activities through the Bureau to the AOA Board of Trustees for approval.

14. Establish a recertification process, as approved by the Bureau and the AOA Board of Trustees, and offer a recertification process no later than january 1, 1995. Issue certificates of recertification to candidates who successfully complete the recertification process. (B-7/92)

ARTICLE II - MEMBERS

The American Osteopathic Board of _____ shall consist of ____(#)__ members elected by the Board of Trustees of the American Osteopathic Association at its annual meeting from nominees submitted by the (specialty affiliate) at its annual meeting, through this Board to the Bureau at its annual meeting and the AOA Board of Trustees. Each member shall be an AOA certified physician in good standing. Insofar as practical, membership shall include a representative from each area of (specialty or field of practice) and a representative from each of the time divisions of the United States. (B-3/84; 7/93)

Section 1. - Election

A. The governing body or voting membership (designate which) of the (specialty affiliate) shall select annually, one (1) candidate for each expiring term on the Board.

B. Should a nominee submitted, fail to be approved by the Bureau or the AOA Board of Trustees, then the (specialty affiliate) shall submit the name(s) of a different qualified individual(s). Said new nominee shall be submitted at the next meeting of the Bureau, which follows the date when the (specialty affiliate) was officially notified of the action of the Bureau or the AOA Board of Trustees.

C. In the event a new nominee(s) has not been submitted by the time and in the manner set forth above, then the chairman of the Bureau shall recommend to the AOA Board of Trustees a qualified candidate(s) to fill the vacancy on this Board. The nominee's term shall be for the balance of the unexpired term.

Section 2. - Term of Office

A. Members shall be elected for terms of _____ (#) years. The terms shall be staggered so that the new members elected in any year shall not constitute a majority of this Board.

B. Whenever a vacancy occurs on this Board due to the death or resignation of a member whose term has not expired, the procedure outlined above shall be followed. If it is deemed urgent that the approval of the nominee be considered prior to the next annual meeting of the AOA Board of Trustees, a nominee may be submitted, according to established procedure, to the Board of Trustees at its next scheduled meeting. If approved, the nominee's term shall run until July of the year it expires.

C. Members shall continue to serve until their successors are elected.

ANESTHESIOLOGY

American Osteopathic Board of Anesthesiology
(Established 1956)
Chairman: Vincent F. D'Angelo, DO
Vice-Chairman:
Bruce E. Weaver, DO
Secretary-Treasurer:
Jeffrey V. Kyff, DO
Corresponding Secretary:
Diann Hubbard, 17201 East U.S.

Requirements for certification
Section 1. The minimum requirements to be eligible to receive certification from the AOA through the American Osteopathic Board of Anesthesiology are as follows:

1. The applicant must be a graduate of an AOA-accredited college of osteopathic medicine.
2. The applicant must be licensed to practice in the state or territory where the practice is conducted.
3. The applicant must be able to show evidence of conformity to the standards set forth in the Code of Ethics of the AOA.
4. The applicant must have been a member in good standing of the AOA or the Canadian Osteopathic Association for the two (2) years immediately prior to the date of certification.
5. The applicant must have satisfactorily completed an AOA-approved internship.
6. The applicant must have satisfactorily completed a minimum of three (3) years of AOA-approved formal training in anesthesiology after the required AOA-approved internship.
7. It shall be the policy of the Board to accept training in anesthesiology taken in hospitals or institutions other than those approved for such training by the AOA as meeting the requirements for formal training subsequent to internship, providing at least two (2) years of formal training in anesthesiology has been taken in a hospital approved for such training by the AOA; and the balance of the training program has been approved by the Committee on Postdoctoral Training of the American Osteopathic College of Anesthesiologists and the Council on Postdoctoral Training of the AOA.
8. Subsequent to the completion of the required minimum of three (3) years of formal training, the applicant for the clinical examination shall have practiced as a specialist in anesthesiology.
9. Following satisfactory compliance with the prescribed requirements for examination, the applicant is required to pass appropriate examinations planned to evaluate an understanding of the scientific bases of the

DERMATOLOGY

American Osteopathic Board of Dermatology
(Established 1945)
Chairman: David Brooks Walker, DO
Vice-Chairman: Charles G. Hughes, DO
Secretary-Treasurer:
Thomas H. Bonino, DO,
25510 Plymouth Rd.,
Redford, MI 48239
(313) 937-1200.
Members: Roger C. Byrd, DO; Lloyd Cleaver, DO; Dudley W. Goetz, DO; David C. Horowitz, DO., Michael Mahon, D.O.

Definition of specialty practice
For the purpose of the operation of this Board

3. The applicant must be able to show evidence of conformity to the standards set in the Code of Ethics of the AOA.
4. The applicant must have been a member in good standing of the AOA or the Canadian Osteopathic Association for a continuous period of at least two years immediately prior to the date of certification.
5. The applicant must have satisfactorily completed an AOA-approved internship. Certifying boards may accept a minimum of five years in general practice in lieu of one year of internship for those who graduated in 1946 and prior thereto.
6. A period of three years of AOA-approved training related to the specialty of dermatology is required, after the required one year of internship, or its equivalent. This Board may modify the requirement by allowing a credit of one year of training toward certification for each five years of practice in the same field for physicians who graduated prior to 1946, but in no case may such applicant be accepted for examination without at least one year of approved training. This training shall include: active experience in diagnosis and treatment in such amount and diversity that it will assure adequate training in the specialty of dermatology.
7. The applicant may be allowed to take the examination at the first annual meeting following the completion of the required three years of approved training providing the documentation is in order and completed by April of that year.

certificates issued after January 1, 1994.

FAMILY PRACTICE

American Osteopathic Board of Family Physicians
(Established 1972)
Chairman: Frank J. Mc Devitt, DO
Vice-Chairman:
Frank A. Bonifacio, DO
Secretary: Joseph Pellettiere, Jr., DO
Treasurer: Robert B. Finch, DO
Executive Director:
Carol Thoma, MBA
330 E. Algonquin Rd., Ste. 2
Arlington Heights, IL 60005
(708) 640-8477

Requirements for certification

Section 1. To be eligible to receive certification from the AOA upon the recommendation of the American Osteopathic Board of Family Physicians, the applicant must meet all of the following minimum requirements, as provided in this article:

1. The applicant must be a graduate of an AOA-accredited college of osteopathic medicine.
2. The applicant must hold a valid, unrestricted license to practice medicine in a state of the United States where his/her practice is conducted.
3. The applicant must have been a member in good standing of the AOA for a continuous period of at least two years immediately prior to the date of application and examination.
4. The applicant must have satisfactorily completed an AOA-approved internship. If graduated in 1946 or prior thereto, the applicant must have had training equivalent to that of an acceptable internship as determined by this Board.
5. The applicant must be able to show evidence of conformity to the standards set in the Code of Ethics of the AOA.
6. The applicant must have completed an AOA-approved family practice residency training program of at least one year prior to July 1, 1989 or of two years beginning July 1, 1989, after the required AOA-approved internship. The candidate may apply for examination during the spring of the final year of training and must successfully complete a written and oral/practical (performance evaluation) examination. After successful completion of all examinations, completion of the residency program and approval of the residency scientific paper and documents required by the AOA and the American College of Osteopathic Family Physicians, the candidate will be recommended for certification. The period of board eligibility is six years; the examination must be successfully completed, the paperwork approved and the

INTERNAL MEDICINE

American Osteopathic Board of Internal Medicine
(Established 1942)
Chairman: Ronald L. Walsh, DO
Vice-Chairman: Joanna Pease, DO
Secretary-Treasurer:
James S. Seebass, DO
Executive Director:
Gary L. Slick, DO
5200 S. Ellis Ave.
Chicago, IL 60615
(312) 947-4881

Requirements for certification

Section 1. To be eligible to receive certification from the AOA through the American Osteopathic Board of Internal Medicine the applicant must meet all the following minimum requirements:

1. The applicant must be a graduate of an AOA-accredited college of osteopathic medicine.
2. The applicant must be licensed to practice in the state or territory where his/her practice is conducted.
3. The applicant must have been a member in good standing of the AOA or of the Canadian Osteopathic Association for a continuous period of at least two years immediately prior to the date of certification.
4. The applicant must have satisfactorily completed one of the following AOA-approved postdoctoral training programs:
   1) Twelve months of a rotating internship followed by 36 months of an internal medicine residency (not necessarily running 36 consecutive months). Candidates may receive month-for-month credit for training in internal medicine taken during the internship, which may be applied towards the 36 months of internal medicine residency requirement.
   2) Twelve months of a rotating internship followed by 24 months of an internal medicine residency and 12 months of a medicine subspecialty. The 24 months of internal medicine residency must precede the subspecialty training.

California Business Portal
Secretary of State Kevin Shelley

DISCLAIMER: The information displayed here is current as of SEP 17, 2004 and is updated weekly. It is not a complete or certified record of the Corporation.

Corporation		
AMERICAN COLLEGE OF CHIROPRACTIC SPECIALISTS		
Number: C0463935	**Date Filed:** 1/15/1964	**Status:** active
Jurisdiction: California		
Mailing Address		
1030 BROADWAY STE 101		
EL CENTRO, CA 92247		
Agent for Service of Process		
WILLIAM VALUSEK		
1030 BROADWAY STE 101		
EL CENTRO, CA 92247		

For information about certification of corporate records or for additional corporate information, please refer to Corporate Records. If you are unable to locate a corporate record, you may submit a request to this office for a more extensive search. Fees and instructions for requesting this search are included on the Corporate Records Order Form.

Blank fields indicate the information is not contained in the computer file.

If the status of the corporation is "Surrender", the agent for service of process is automatically revoked. Please refer to California Corporations Code Section 2114 for information relating to service upon corporations that have surrendered.